STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. BUILDING _____ B. WING _____	12/21/2007

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EVERGREEN AT CC HEALTH & REHAB	3050 N ORMSBY CARSON CITY, NV 89703

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey, a state survey and a complaint survey conducted at your facility on 12/17/07 through 12/21/07. The census at the time of the survey was 102. The sample size was 25 including 3 closed records. There were 4 complaints investigated during the survey: CPT # NV00016809 alleged that the facility failed to provide quality care to a resident. The complaint was substantiated with federal deficiencies cited. See F327 and F274. CPT # NV00016767 was a facility reported incident involving a resident who sustained a burn to the upper lip while smoking unsupervised. The complaint was substantiated with a federal deficiency cited. See F323. CPT# NV00016200 alleged poor quality of care. The complaint was not substantiated. CPT# NV00016960 alleged abuse and poor quality of care. The complaint was not substantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000	DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLEY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. RECEIVED JAN 18 2008 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA **F167 Examination of Survey Results** **Residents with Potential Risks** All residents have the potential to be harmed by failure to follow this policy. **Corrective Action** A notice indicating the contents of the facility's current survey, plan of correction and complaints has been posted above the plastic holder containing the notebook with the most current survey, plan of correction and complaints. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** Sign has been posted. Executive Director, Maintenance Director, and Director of Nursing will monitor that notice remains posted through regular daily rounds. Sign will be replaced by Maintenance Director as needed. Approved mf 1/25/08 2/6/08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Bohannon | TITLE: Executive Director | (X6) DATE: 1/18/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to report a significant change in the resident's physical condition in 1 of 25 residents. (Resident # 17)	F 157	**F157 Notification of Changes** It is the policy of this facility that the physician, resident and/or resident's responsible party is notified of any accident that results in injury, a significant change in the resident's status, a need to alter treatment or a decision to transfer or discharge a resident from the facility. **Residents with Potential Risks** Resident #17 was not harmed by the failure to follow this policy. All residents have the potential to be harmed by failure to follow this policy. **Corrective Action** Resident #17 has discharged from the facility. Director of Nurses will in-service licensed nursing staff on requirement that physician and resident and/or resident's responsible party will be notified of any change of condition in a resident's status. Director of Nurses will in-service nursing staff by February 6, 2008. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** CQI audit tool "Notification of Changes" will be used to identify others having the potential to be affected by the same deficient practice. Director of Nurses will do random checks on change of condition documentation monthly to ensure deficiency is corrected. Findings will be brought to quarterly CQI meeting.	

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F 157	Continued From page 2 Findings Include: Resident #17: The resident was admitted to the facility on 3/17/07. The resident's admitting history and physical revealed that the resident was admitted to the facility to increase the resident's functional status. The resident's diagnoses included dementia, congestive heart failure, hypertension, chronic obstructive pulmonary disease and hypoxemia. Resident #17's admitting history and physical, dated on 3/19/07 revealed that the resident's "pupils are equal, round, and reactive to light." " The patient ambulates." "She has good balance, good sitting, and good bed mobility." "She also is continent of bowel and bladder." The nurse's notes dated 8/16/07 revealed that Resident #17 had a fall. The nurse's notes dated 8/17/07 revealed that the resident's right pupil was not responsive to light. The neurological assessment flowsheet, dated 8/16/07 to 8/18/07, revealed that the resident's right pupil was not responsive to light. There was no evidence found that the doctor was notified of this significant finding. The director of nursing was interviewed on 12/19/07 and was not able to provide evidence that the resident's physician had been notified of this finding.	F 157	**F221 Physical Restraints** It is the policy of this facility that physical restraints have a physician's order . **Residents with Potential Risks** Resident #8 was not harmed by the failure to comply with this policy. All residents have the potential to be harmed by failure to follow this policy. **Corrective Action** Physician's order was obtained for seat belt for resident #8. Audit of residents with physical restraints will be conducted by Medical Records or her designee to ensure that residents with physical restraints have physician orders for them. Director of Nurses will in-service licensed staff on requirement that physician's order be obtained prior to initiation of restraint by February 6, 2008. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** Director of Nurses or her designee will do random chart review of physical restraints to ensure that a physician's order has been obtained prior to use of physical restraint every month for three months and then quarterly thereafter. Findings will be reported to the quarterly CQI meeting.	Accepted MG 1/30/08 2/6/08
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221		

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F 221	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to obtain a physicians order for physical restraint for 1 out of 25 residents.(Resident #8) Findings include: Resident #8: The resident was admitted on ++++ with On initial tour of facility resident #8 was observed in a wheel chair with a tabs alarm and a lap belt in place. The lap belt observed was not the self releasing type. Record review revealed that the resident had a history of falls. The Pre-Restraint Assessment and Informed Consent were completed on 10/31/07. These records identified the need for restraint, the type of restraints to be used and the benefits and risks of using the restraints. The care plan dated 12/12/07 identified the use of restraint device as ordered by the Medical Doctor and family agreement for fall prevention. Review of the physician's orders with the Licensed Practical Nurse confirmed there was no order for the use of the lap belt restraint.	F 221	**F225 Staff Treatment of Residents** It is the policy of this facility to report all allegations of abuse to the Executive Director or his designee within 24 hours of discovery. **Residents with Potential Risk** Residents #6 and #19 were not harmed by the failure to comply with this policy. All residents have the potential to be harmed by the failure to comply with this policy. **Corrective Action** Resident #6's allegation that a man kissed him on the lips was fully investigated. Result of investigation was that allegation could not be substantiated. Resident #19's allegation that an ATM card is missing has been investigated and result of investigation indicates that allegation cannot be substantiated. Director of Nurses will in-service staff on policies and procedures regarding reporting allegations of abuse to Executive Director or, in the absence of the Executive Director, his designee within 24 hours of discovery; results of investigation must be reported to state bureau of certification and licensure within 5 working days; employee making discovery is required to report allegation immediately to supervisor; discovering employee completes appropriate area of event report. Staff will be in-serviced by February 6, 2008.	Accepted MP 1.30.08
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225		

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F 225	Continued From page 4 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's policies and procedures it was determined that the facility failed to implement the facility's written policies and procedures that require the reporting and investigation of all allegation of abuse, neglect of residents or misappropriation of resident property in 2 of 25 residents. (Residents #6 and #19) Findings Include:	F 225	**Implemented Measure to Ensure Compliance/Monitoring of Compliance** Current staff will be in-serviced on abuse prohibition as evidenced by in-service documentation. New staff will have abuse prohibition as part of their orientation within the first thirty days of employment as evidenced by signed acknowledgement of in-service. Staff Development Coordinator and Payroll will audit employee files to ensure in-servicing of staff on abuse prohibition every month for three months and quarterly thereafter.	2/6/08

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F 225	Continued From page 5 Review of the facility's policy and procedure titled, "Event Reporting and Investigation" revealed that, "Events involving allegations of abuse, neglect, mistreatment, injuries of unknown source, or misappropriation of resident property are immediately reported to the Executive Director or, if the Executive Director is not available, his or her designee." The policy and procedure revealed that "immediately means as soon as possible but not to exceed 24 hours." The policy directed, "The nurse caring for the resident documents in the Progress Notes in the medical record the details of the event, the initiation of the investigation process and the notification of the attending physician and the resident's authorized representative." Section B Regulatory Reporting documented the following procedure: 1. "Events involving allegations of abuse, neglect, mistreatment, misappropriation or resident property... are reported immediately to the state survey and certification agency." 2. "The facility reports investigation findings to the Executive Director." 3. "Results of investigations of events involving... misappropriation of resident property... are reported to the state survey and certification agency within 5 working days of the event." Event investigation documented the following procedure: 1. "When an event is discovered, the employee making the discovery should immediately notify their immediate supervisor." 7. "The discovering employee completes the appropriate portion of the Event Report...prior to the completion of his or her shift and makes notifications per policy and processes."	F 225		

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F 225	Continued From page 6 Resident #6: The resident was admitted to the facility on 12/11/07 with diagnoses of senile dementia, hypertension, hypothyroidism, anxiety and ischemic heart disease. On 12/17/07, at 10:30 AM, a surveyor overheard Resident #6's wife report to the speech therapist that someone had kissed her husband last night and he did not like it. The resident's wife reported that the resident stated, "I didn't like it - didn't appreciate that." In interview the speech therapist stated she was an employee of the facility. When asked what she was going to do with the information, the speech therapist replied that the resident's wife had already reported it to the nurse. If the resident's wife had not reported it she would report it to social services. " On 12/17/07, at 10:45 AM, Resident #6 and the resident's wife were interviewed regarding the allegation. The resident reported that the man that writes prescriptions was the man that kissed him last night. That he was kissed on the lips. He stated this several times during the interview. He would toss and turn in bed during the interview. His wife stated that he was anxious. The resident stated that he was sorry that he had said anything because "I feel like I'm in a bad situation" and he did not want to get involved. His wife stated he feared retaliation if he reported the incident. The resident's wife stated that she was concerned that something had happened because the resident kept on repeating the fact that he was kissed during the night. She stated that at times he does say things that are inappropriate but she felt concerned this time because of the resident's persistence that he had been kissed. She stated that she had reported the incident to licensed	F 225		

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F 225	Continued From page 7 practical nurse (LPN) # 1 around 7:00 AM. On 12/17/07, at 11:10 AM, in interview, LPN # 1 stated that Resident #6's wife reported the incident to her in the morning and that she was aware of the incident. LPN # 1 stated that she had not reported the incident. At 11:15 AM, LPN #1 was asked to accompany this surveyor to the Executive Director's office. The Executive Director stated that he was not aware of the incident and that no investigation into the allegation had been initiated. The investigation was not initiated until this surveyor brought LPN# 1 into the Executive Director's office and the incident was reported to him. LPN #1 stated that registered nurse (RN) # 3 who worked last night was very sweet and would make kissing gestures to everyone when he greeted them. Resident #19: The resident was admitted to the facility on 4/20/07 with diagnoses including glaucoma, diabetes mellitus, hyperlipidemia and blindness. On 12/19/07, Resident #19's medical record was reviewed. Review of the social progress notes revealed the following entry by social worker (SW) #2 dated 9/27/07, "Resident came in to tell us he's missing an ATM (automated teller machine) card and about $8.00. (Director of Social Services) will advise his guardian to check on ATM. Discussed setting up account on nurses cart." (This means setting up a place on the medication cart to store the resident's money). Further review of the medical record failed to reveal any follow-up of this incident. On 12/19/07, the Director of Social Services was interviewed. She stated that she did not know that Resident #19 was missing an ATM card or	F 225		

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F 225	Continued From page 8 $8.00 and that there had been no investigation to this event. She stated that the procedure for missing items was to fill out a concern form, or that if it was resolved, there may be no paper work filled out. She stated if a concern form was not filled out that she was not always made aware of incidents. She stated that she was not the facility abuse coordinator. She stated that allegations of physical or verbal abuse go through the Director of Nurses. On 12/20/07, the Director of Social Services and SW #2 were interviewed. SW #2 stated that she did not inform the Director of Social Services and had given Resident #19 $3.00. The Director of Social Services stated that there had been no investigation for the missing ATM card or the money until 12/20/07. The Director of Social Services stated that Resident #19's admission possession's list did not list an ATM card and he could not remember on 12/20/07, when interviewed, if the missing card was a smooth or embossed card. On 12/20/07, Resident #19 was interviewed. He stated that the missing card was an ATM card, but that it was for a closed account.	F 225	**F246 Accommodation of Needs** It is the policy of this facility that all residents have the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences. **Residents with Potential Risks** Residents #5 and #25 were not harmed by the failure to comply with this policy. All residents have the potential to be harmed by failure to comply with this policy. **Corrective Action** Director of Nurses or her designee will in-service staff that call lights must be placed within resident's reach. Resident #25 has discharged from the facility. Director of Nurses or her designee will in-service staff to properly seat residents during meal time to be completed by February 6, 2008. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** Facility's Evergreen Care Representatives will monitor call light placement through regular daily rounds and to ensure that residents are properly seated during meal time. Findings will be reported to Executive Director or his designee.	accepted MB 1/30/08
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced	F 246		

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F 246	Continued From page 9 by: Based on observations it was determined that the facility failed to accommodate for the needs of 2 of 25 residents. (Residents #5 and #25) Findings Include: Resident #5: The resident was admitted to the facility on 12/10/06 with diagnoses of multiple sclerosis, urinary retention, irritable bowel syndrome, osteoporosis and depressive disorder. On 12/21/07, at 8:55 AM, Resident #5 was observed calling for help in her room. There were no staff members noted near the resident's room. This surveyor entered the resident's room and she was observed to be in a chair. She stated she wanted to get back to bed because it "really hurts" being in the chair. The resident's call light was beyond her reach. The resident was physically and cognitively able to use the call light if it had been left within her reach. Resident #25 On 12/17/07, this resident (not on the sample), was observed during the noon meal in the Advantage dining room. She was in a wheelchair with her leg extended. When she wheeled up to the table, she had to place her wheelchair sideways to the table because of the extended leg. The entree for the meal was spaghetti. She had to reach across to her plate, scoop up a serving on her fork, then place her napkin under the serving and convey it back across her body to her mouth. Several staff members were present in her dining area at the time. None of them attempted to facilitate her attempts to eat. Her husband then entered the dining area, and observed her struggles with eating. He then went into her room, returning with her overbed table. He then proceeded to	F 246	Executive Director and Director of Nurses will do random room rounds for call light placement and meal observations for proper positioning weekly and report findings to quarterly CQI meeting.	2/6/08

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F 246	Continued From page 10 place the table over her wheelchair and moved her plate and silver to the overbed table. She was then able to eat with dignity and ease.	F 246	**F278 Resident Assessment** It is the policy of this facility that resident assessments will accurately reflect the resident's status.	
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to accurately reflect the resident's dehydration status in the	F 278	**Residents with Potential Risks** Resident #4 was not harmed by the failure to comply with this policy. See Tag F327 for the specific findings of dehydration. All residents have the potential to be harmed by the failure to comply with this policy. **Corrective Action** Director of Nurses or her designee will in-service MDS nurses regarding the proper assessment and coding of the MDS by February 6, 2008. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** The Director of Nurses or her designee will conduct random audits of the MDS every month for the next three months and quarterly thereafter. Findings will be brought to the quarterly CQI meeting.	Accepted MJ 1.30.08 2/6/08

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 minimum date set (MDS) in 1 of 25 residents. (Resident #4) Findings Include: Resident #4: The resident was admitted to the facility on 10/3/07 with hypertension, anemia, urinary tract infection and renal failure. The physician's history and physical, dated 10/5/07, revealed that the plan for the resident was to have her monitored for renal efficiency and for her urinary tract infection. The resident's readmission (from the hospital) nutritional evaluation revealed that the resident had not been eating or drinking well during her hospitalization. The nutritional evaluation, dated 10/8/07 revealed the resident's fluid requirements to be 1500 milliliters (ml) plus a day. The 60 day Medicare assessment with an assessment reference date of 12/05/07 did not have the box J1c. Dehydrated; Output Exceeds Intake or J1d. Insufficient Fluid; Did Not consume All/Almost all liquids provided during the last three days checked, and the weight in Section K2b did not reveal the most recent weight within the look back period. On 12/21/07, at 9:40 AM, the MDS coordinator stated that she uses the nursing assistant documentation tool to determine whether these boxes need to be checked. Resident #4 met the criteria to have these boxes checked as evidenced by: The nursing assistant documentation tool revealed the following ml per day of fluid intake: 11/29/07 - 480	F 278		

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	295067	A. BUILDING _____ B. WING _____	12/21/2007

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F 278	Continued From page 12 11/30/07 - 360 12/1/07 - 720 12/2/07 - 920 12/3/07 - 600 12/4/07 - 720 12/5/07 - 480 There was no extra fluid intake recorded on the tool. A nurse stated that this tool was the only record in which fluids were documented. The tool revealed that Resident #4's intake was under her 1500 ml per day requirement everyday of the look back period. The resident's laboratory values for 11/26/07 revealed abnormal values indicative of dehydration. There was also a significant weight loss in a short period of time. This fulfilled the needed indicators of dehydration required to check box J1c. Resident #4 did not consume almost all of the liquids provided during the last three days as evidenced by the intake amounts noted for 12/5/07, 12/4/07, and 12/3/07 above. This fulfilled the requirement to check box J1d. Resident #4's weight recorded on the MDS was 107 pounds. On 12/4/07, the resident's weight was 99 pounds. This was an eight pound weight loss in nine days. A significant weight loss in a short period of time may be indicative of dehydration. See Tag F327 for the specific findings of dehydration.	F 278	**F281 Comprehensive Care Plans** It is the policy of this facility that services provided or arranged by the facility must meet professional standards of quality. **Residents with Potential Risks** No residents were harmed by the failure to comply with this policy. All residents have the potential to be harmed by failure to comply with this policy. **Corrective Action** Director of Nurses will in-service licensed staff on the facility's policies and procedures for controlled drugs administration, counting narcotics at change of shift and reporting any discrepancy in the count to the Director of Nurses or her designee for further investigation to be completed by February 6, 2008. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** Director of Nurses or her designee will conduct random observations of narcotic counts at change of shift every month for the next three months and quarterly thereafter. The Director of Nurses or her designee will monitor compliance through random observations and will report findings to the quarterly CQI meetings.	Accepted MJ 1.30.08
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality.	F 281		2/6/08

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F 281	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy review, and interview, it was determined that the facility failed to ensure that services offered meet professional standards of quality for reconciliation of narcotic count discrepancy. Findings include: On 12/21/07, at approximately 7:15 AM, the narcotic count between the night shift nurse and the day shift nurse was overheard on the Brookside unit. There were four discrepancies in the narcotic count. Three of the discrepancies were resolved when the night shift nurse, RN #1, signed for a narcotic given during her shift. RN #1 was interviewed and stated that the previous night had been very busy and she had not signed out the medications as she had given them. The count for Morphine Sulfate SA (sustained action) for an unidentified resident was not reconciled. The count for Morphine Sulfate SA was short two, and the day shift nurse, LPN #4, had the assistant director of nurses (ADON) sign for the actual amount of Morphine Sulfate SA in the narcotic drawer. LPN # 4 was interviewed and stated that she would work on reconciling the narcotic count after she passed medications. On 12/21/07, in interview the ADON stated that if the narcotic count was not correct, the day nurse would go through the medication administration records (MARs) to try to determine who received the narcotic. On 12/21/07, at approximately 10:30 AM, the ADON produced the controlled drug record for	F 281		

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F 281	Continued From page 14 the Morphine Sulfate SA. She stated that per the MARs, the unidentified resident had received one Morphine SA on 12/19/07 at 8:00 PM, and one on 12/20/07 at 8:00 AM by two different nurses. She stated that it is policy to count each narcotic at the change of shift, with the oncoming nurse and the offgoing nurse performing the narcotic count. The ADON could not explain how the count had not been reconciled since the morning narcotic count of 12/20/07. On 12/21/07, the facility's policy and procedure for controlled drugs was reviewed. The policy was documented as, "Drugs listed in Schedules II through V of the Controlled Substances Act possess high abuse potential and are subject to special handling, storage, disposal, and record keeping." Procedure 7: "Immediately after a dose is administered, the licensed nurse administering the drug enters all of the following information on the Controlled Drug Accountability Record: a. Date and time of administration. b. Dose administered... c. Signature of the nurse administering the dose..." Procedure 9: "A physical inventory of all Schedule II drugs must be made at the change of each shift by two licensed nurses and is documented on an audit record." Procedure 11: Report any discrepancy in controlled drug counts to the director of nursing or designee immediately. The director or designee shall investigate and make every reasonable effort to reconcile all reported discrepancies. Document irreconcilable discrepancies in a report	F 281		

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F 281	Continued From page 15 to the director of nursing and the Executive Director..."	F 281	**F323 Accidents and Supervision** It is the policy of this facility that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. **Residents with Potential Risks** Resident #24 sustained a burn to his upper lip as a result of the failure to comply with this policy. Residents who smoke have the potential to be harmed by failure to comply with this policy. Residents who smoke will be evaluated for safety to identify others having the potential to be affected by the same deficient practice. **Corrective Action** Resident #24's care plan has been changed to reflect the current need to be supervised while smoking. The smoking assessments and care plan of residents who smoke will be reviewed for the need to be supervised while smoking. A CNA Alert form will be placed in the front of ADLs for those residents requiring supervision while smoking and reviewed quarterly at care conference. The Director of Nurses or her designee will in-service staff on the facility's smoking policy and on the supervision requirement for residents needing supervision while smoking to be completed by February 6, 2008.	
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review and resident/staff interviews, the facility failed to ensure resident received adequate supervision to prevent accidents for 1 of 25 residents (Resident #24). Findings include: Resident #24 was admitted to the facility on 10/07/04, diagnosis includes congestive heart failure, chronic obstructive pulmonary disease, anxiety, depressive disorder, venous insufficiency, insomnia, sleep apnea and back pain. The resident's medications and treatments included Advair Discus 250/50 (1 puff) Inhalation two times daily, Neurontin Capsules 300 milligrams one daily, Ativan 2 milligrams every 6 hours as needed, Atrovent Nebulizer as necessary, Vicodin Tablets 500 (one tablet) mild to moderate back pain every four hours as needed, Vicodin Tablets 500 (two tablets) moderate to severe back pain every four hours as	F 323		

Accepted MF 1/30/08

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F 323	Continued From page 16 needed, Methadone 50 milligrams three times daily, Lexapro 10 milligrams two times daily, Oxygen at 5 liters per minute (6 liters continuous). The side effects or adverse reactions to Neurotin, Vicodin, Methadone and Lexapro include sedation, somnolence, fatigue, lethargy, dizziness, depression, clouded sensorium, impaired concentration, abnormal thinking, incoordination and respiratory depression. A previous complaint, complaint # NV00015493 involved Resident #24 where on 07/27/07 the resident had been outside smoking with their oxygen on and sustained a burn to the upper lip and right cheek, this complaint was investigated and substantiated as the facility failed to enforce the smoking policy and adequately supervise the resident to prevent the injury, federal deficiencies were cited at F323 on 08/02/07. On 12/18/07 at 8:40 AM, Resident #24 was observed in his room, slumped forward sitting in his wheelchair. The oxygen tank was mounted on the wheelchair was running at 6 liters per minute with the nasal cannula appropriately in place on the resident. The oxygen concentrator at the beside was also observed to be running at 8 liters per minute. When approached, Resident #24 was easily aroused. It took few minutes for him to be fully alert and cognizant. Resident #24 was then interviewed about the burn to his upper lip. He stated that the incident had happened earlier this month (December), had been out smoking and lit the wrong end of the cigarette. He confirmed that he was unsupervised at the time. From 12/18/07 through 12/21/07 the resident 's medical records were reviewed. The Smoking	F 323	**Implemented Measure to Ensure Compliance/Monitoring of Compliance** The Director of Nurses or her designee will observe residents who smoke for compliance and safety every month for three months and quarterly thereafter with results reported to the quarterly CQI meeting.	2/6/08

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F 323	Continued From page 17 Safety Evaluation completed on 7/30/07 identified a history of smoking related incidents, lethargy and need for supervision when smoking by staff. Review of the incident report revealed that Resident #24 sustained a burn to his upper lip while lighting a cigarette unsupervised on 12/06/07. The 12/06/07 incident was witnessed by the facility receptionist. On 12/21/07 at 11:05 AM the receptionist's written statement was reviewed. In interview, she confirmed the resident was unsupervised when the 12/06/07 incident occurred. The care plan dated 08/24/07 which addressed smoking and was in effect at time of the12/06/07 incident, read: " Problem: Resident has tendency to be non-compliant in turning off oxygen when he smokes; Goal: Resident will not injure self or others over next 90 days; Interventions: Staff will alert nursing, social services or administrator if they see resident smoking with oxygen on; social worker will intervene as possible, administrator will become involved as needed " This care plan was last reviewed and/or extended to 10/05/07. The care plan in effect at the time of the 12/06/07 incident failed to address the 07/30/07 Smoking Safety Evaluation which had identified the need for supervision while smoking.	F 323	**F325 Nutrition** It is the policy of this facility that all residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. **Residents with Potential Risks** Resident #5 has the potential to be harmed by failure to comply with this policy. All residents have the potential to be harmed by failure to comply with this policy. **Corrective Action** Care plan for resident #5 will be adjusted to offer preferred snacks as an alternative to the Resource supplements and health shakes that resident refuses. Resident #5 also included in Nutrition/Weight/Skin Committee for weight and nutritional review. Nutritional Committee will meet weekly to review residents with significant weight loss and make appropriate intervention to prevent further weight loss. Care plan will be updated to indicate issues of weight loss. Director of Nurses will in-service Nutritional Committee to implement all available interventions to limit weight loss and make referral to Registered Dietician by February 6, 2008. The Director of Nurses and the Staff Developer will in-service CNAs to offer HS snacks to each resident unless contraindicated by resident's medical condition to be completed by February 6, 2008.	Accepted MF 1-30-08
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325		

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F 325	Continued From page 18 demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to implement all available interventions to limit the weight loss in 1 of 25 residents. (Resident #5) Findings Include: Resident #5: The resident was admitted to the facility on 12/10/2006 with diagnoses of multiple sclerosis, urinary retention, irritable bowel syndrome, osteoporosis and depressive disorder. Resident #5's annual nutrition evaluation, dated 11/8/07 revealed the resident's height was five feet and three inches. Her ideal body weight was 115 pounds. The following weights were recorded: On 1/2007 the resident weighed 138 pounds. On 5/2007 the resident weighed 126 pounds. On 8/2007 the resident weighed 112 pounds. On 10/2007 the resident weighed 103 pounds. On 11/3/07 the resident weighed 102 pounds. The record revealed the dietician's notes, dated 12/3/07 revealed that Resident #5 refused Resource supplements and health shakes. The Nutritional Status Interdisciplinary care plan, did not address any alternatives, such as offering snacks as a replacement for the shakes and supplements Resident #5 had refused. that Resident #5 remained at 102 pounds on 12/4/07, 13 pounds under her ideal body weight.	F 325	**Implemented Measures to Ensure Compliance/Monitoring of Compliance** Nutrition/Hydration/Skin Committee will monitor resident #5's weight weekly for thirty days and will refer to Registered Dietician as needed. Resident Council minutes will be reviewed by Executive Director to monitor resident satisfaction with snack program. Dietary Manager will oversee types of snacks preferred by resident and ensure that they are being sent from the kitchen to nourishment rooms. Refer also to **F368 Frequency of Meals.** The Director of Nurses or her designee will monitor compliance of the Nutrition Committee, its recommendations and referrals to the Registered Dietician.	Accepted 2/6/08

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F 325	Continued From page 19 On 12/18/07, at 2:45 PM, Resident #5 stated that she does not get her bedtime snack and would like to have her snack because she becomes hungry without snacks. The nursing assistant documentation tool had HS (bedtime) snack hand written in under the diet portion. No snacks were documented as given from December 12/1/07 through 12/17/07. On 12/18/07, at 2:20 PM, an interview with the director of nursing and the staff development coordinator revealed that staff do not offer snacks to each resident but that snacks are available if they want them. On 12/18/07, at 11:05 AM, the dietary services manager stated that a snack list was maintained with the names of residents that wanted snacks. A review of the snack list revealed that Resident #5 was not on the list. On 12/21/07, at 10:40 AM, Resident #5 stated that she was hungry and that she wanted a snack. She stated that she loved snacks. She stated that she was never told that snacks were available and was not offered snacks. On 12/20/07, at 1:30 PM, by telephone interview the dietician stated that Resident #5 has end stage multiple sclerosis and that she could not force the resident to eat. She was asked if snacks were offered to the resident. She stated that nursing could do that and that bedtime snacks should always be offered to residents. The nursing assistant documentation tool revealed that Resident #5 consumed the following percentages of her meals between 12/1/07 and 12/17/07: Breakfast: Less than 50 percent was consumed	F 325		

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F 325	Continued From page 20 on six days. Greater than 50 percent was consumed on 11 days Lunch: Less than 50 percent was consumed on three days. 50 percent was consumed on four days. Greater than 50 percent was consumed on 10 days. Dinner: Less than 50 percent was consumed on two days. 50 percent was consumed on three days. Greater than 50 percent was consumed on 12 days. On 12/18/07 Resident #5 was observed in the assisted dining room for breakfast. She was observed to eat all of her pancakes when assisted by a staff member. The facility's policy and procedure manual revealed that a Nutrition/Hydration/Skin Committee will evaluate residents with declining nutrition/hydration/skin status. The director of nursing stated that these meetings had not being conducted since she started with the facility in July of 2007. During the survey Resident #5 had complained of hunger twice, on 12/18/07 and 12/21/07, in between meals. There were no interventions in place to encourage the resident to receive snacks in between meals. The resident's weight was below her ideal body weight. She was observed to eat when assisted. There were days, as noted above, in which the resident ate less than 50 percent of her meals.	F 325	**F327 Hydration** It is the policy of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health. **Residents with Potential Risks** Resident #4 , #17 and #18 were admitted to acute care with diagnoses of dehydration. All residents have the potential to be harmed by failure to comply with this policy. Audit of residents at risk for dehydration due to decreased fluid intake will be conducted to identify others having the potential to be affected by the same deficient practice. **Corrective Action** Change of Condition is recorded on telephone orders and/or the 24 hour book at each nursing station. Director of Nurses will review telephone orders and 24 hour book at the morning management meeting. Director of Nurses will develop a list of residents to be reviewed at the Nutrition Committee meeting. Nutrition/Hydration/Skin Committee (referred to as Nutrition Committee) has been created that includes the Registered Dietician (when available), Director of Nurses and/or designee, Dietary Manager, RNA Staff, Activity Director and Social Services and meets weekly.	
F 327 SS=G	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		

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F 327	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined that the facility failed to provide each resident with sufficient fluid intake to maintain proper hydration and health in 4 of 25 residents. (Residents #4, #13, #17 and #18)) Findings Include: Resident #4: The resident was admitted to the facility from the hospital on 10/3/07 with hypertension, anemia, urinary tract infection and renal failure. The physician's history and physical, dated 10/5/07, revealed that the plan for the resident was to have her monitored for renal efficiency and for her urinary tract infection. The resident's nutritional evaluation revealed that the resident had not been eating or drinking well during her hospitalization. The nutritional evaluation, dated 10/8/07 revealed Resident #4's daily fluid requirements to be 1500 milliliters (ml) or greater per day. The nursing assistant documentation tool revealed the following milliliters per day of fluid intake: 11/29/07 - 480 11/30/07 - 360 12/1/07 - 720 12/2/07 - 920 12/3/07 - 600 12/4/07 - 720 12/5/07 - 480 12/6/07 - 590 12/7/07 - 600	F 327	Residents at risk for dehydration (significant weight loss, poor fluid intake, history of dehydration, infection, antibiotic therapy) will have intake and output documented on separate intake and output forms for seven days to monitor for dehydration. New admits will be placed on I & O screening for seven days and will be reviewed by Nutrition Committee. Dietary Manager will interview Resident #4 to determine beverage preferences. Those preferences will be made available to Resident #4 in her room along with water and will alternate in flavor, according to resident's preferences to maintain interest in hydration. Resident #13 has discharged from the facility. Resident #17 has discharged from the facility. Resident #18 has, per family request, been placed on Hospice Services. Family has requested that no intervention be conducted regarding resident's nutrition and hydration or lack thereof. Residents at risk for dehydration will be reviewed weekly by the Nutrition Committee and care plans will be adjusted as needed to include individualized plans of care to encourage adequate intake.	Accepted MJ 1/30/08

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F 327	Continued From page 22 12/8/07 - 840 12/9/07 - 720 12/10/07 -1200 12/11/07 - 720 12/12/07 - 480 12/13/07 - 480 12/14/07 - 560 12/15/07 - 360 12/16/07 - 400 There was no extra fluid intake recorded on the tool. A staff nurse stated that this tool was the only record in which fluids were documented. On 12/21/07, at 9:10 AM, in interview, the dietician stated that she does not monitor residents fluid status. She stated that hydration is a problem at this facility as it is at all facilities. She stated that there is not enough staff to do all of the monitoring that is required. She stated that it is the nursing departments' responsibility to recognize dehydration and bring it to the attention of the dietician. On 12/21/07, at 9:40 AM, the director of nurses (DON), stated that nurses do not normally look at the intake portion of the nursing assessment documentation tool. The minimum data set (MDS) coordinator stated that she does use the tool to determine the indicators of fluid status for the MDS. A MDS was completed with an assessment reference date that captured dates with poor fluid intake as noted above. The MDS section which indicates dehydration and insufficient fluid was not marked. See Tag F278 for details on the MDS. There was no evidence found that Resident's #4's intake was being monitored by the dietician, nursing staff, or the minimum data set	F 327	Director of Nurses or her designee will in-service licensed staff on Hydration policies and procedures and to notify physician when intake is not adequate. A hydration program will be initiated in which a variety of beverages are offered to residents twice daily outside of meal times. HS Snack carts will contain beverages other than water to offer residents. **Refer also to F25 and F368.** Blender to make milkshakes will be purchased for the kitchen. The Director of Nurses will in-service licensed staff regarding following physician orders for labs draws in a timely manner and notification to the physician of reduced fluid intake. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** The Director of Nurses or her designee will oversee the implementation and ensure compliance of the intake and output documentation. The Director of Nurses will chair the Nutrition Committee ensuring that the appropriate residents are reviewed, that care plans are appropriately adjusted by the Committee.	

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F 327	Continued From page 23 coordinator. On 12/18/07, at 9:20 AM, LPN #3 stated that staff encouraged Resident #4 to drink fluids but that she would not cooperate. She stated she would go in and help the resident get started with drinking fluids but that as soon as she would leave the resident would stop drinking. She stated that certified nursing assistants also attempted to encourage the resident to drink fluids. She stated that she attempted to get the resident ice cream blended with milk but that the kitchen staff told her that the resident could not have these shakes because if they made them for her than they would have to make them for every one. The dietary manager was asked if the kitchen would supply a milkshake to a resident if asked for one. The dietary manager stated that the kitchen did not have the equipment, a regular blender, to make these types of shakes otherwise they would provide them. Resident #4 was hospitalized on 12/17/07 and was not available to be interviewed. Resident #4's weight was documented as 107 pounds on 10/23/07, 11/5/07, 11/11/07, 11/18/07, and 11/25/07. On 12/4/07, the resident's weight was 99 pounds. This was an eight pound weight loss in nine days. The resident's weight was 96 pounds on 12/9/07. This was a three pound weight loss in five days. According to the Manual of Clinical Dietetics, American Dietetic Association, Sixth Edition, weight loss is a sign of dehydration (2.2 pounds is equivalent to 470 milliliters). The manual also revealed that "the assessment of a client's hydration status is quick and easy to to do, and should include an	F 327	The Nutrition/Hydration/Skin Committee will review intake and output documentation weekly and make recommendations based on findings. Residents at risk for dehydration will be reviewed by the Nutrition/Hydration/ Skin Committee until fluid intake is adequate for one month.	2/6/08

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F 327	Continued From page 24 assessment of fluid intake." The dietician's notes, dated 12/12/07, revealed that on 12/9/07 the resident weighed 96 pounds and had a 10% weight loss. It revealed that the resident was put on a regular diet and health shakes. It also identified the resident as having a potential for weight gain. There was no evidence found in the dietician's notes regarding the time frame in which this weight loss occurred and no evidence was found to determine the cause of the sudden weight loss. Resident #4's laboratory results on 11/26/07 revealed the following: Sodium: 119 - Normal levels are 136 - 144 Glucose: 112 - Normal levels are 60 - 99 Urea Nitrogen: 55 - Normal levels are 8 - 20 Creatinine: 2.0 - Normal levels are 0.4 - 1.0 According to the Manual of Clinical Dietetics, American Dietetic Association, Sixth Edition - increased urea nitrogen and creatinine are indicative of dehydration. The doctor's orders, dated 11/28/07 revealed Resident #4 was to have a basic metabolic panel (BMP) drawn weekly. The next BMP was due on 12/3/07. There was no evidence found in the record that a BMP was drawn on 12/3/07, 12/10/07 and 12/17/07. The director of nursing confirmed that the BMP's were not drawn as ordered by the physician. A BMP includes laboratory values that may be used to evaluate renal function as well as hydration status. On 12/17/07 Resident #4 went to a doctor's appointment and was transferred to the hospital from the doctor's office. The admitting history and physical, dated 12/17/07, revealed that the	F 327		

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F 327	Continued From page 25 chief complaint was dehydration. The assessment/plan revealed the following: "This patient is a 77-year old female presenting with two weeks of continuous mild vaginal bleeding and clinical evidence of severe dehydration with acute renal failure." "The patient will be admitted to the general medicine floor where she will continue to receive IV (intravenous) fluids as prescribed by (name left out) and be reevaluated in the morning to see if her renal function and her acidemia has responded to IV fluid hydration. Resident #4's laboratory values, dated 12/17/07 at 4:40 PM revealed the following: Sodium - 121 Glucose - 152 Urea Nitrogen - 101 Intravenous fluid boluses were ordered on 12/17/07 at 11:30 PM and on 12/18/07 at 3:00 AM. IV fluids were also ordered to continue on 12/18/07 at 5:00 AM. Resident #4's laboratory results on 12/18/07 at 8:20 AM, revealed the following: Sodium - 136 Glucose - 102 Urea Nitrogen - 55 If Resident #4's BMP's had been drawn on 12/3/07, 12/10/07 and 12/17/07 as ordered by the physician the resident's dehydration may have been caught at an earlier stage and hospitalization may have been avoided. The facility's policy and procedure manual revealed that a Nutrition/Hydration/Skin Committee will evaluate residents with declining nutrition/hydration/skin status. The DON stated in	F 327		

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interview, that these meetings had not being conducted since she started with the facility in July of 2007. On 12/21/07, at 9:10 AM, the dietician stated that one of the corporate staff members stated that there was no need to conduct these meetings. The dietician stated that she felt that these meetings should be occurring and that it was important for the dietician to participate in these meetings.

There was no evidence found that the physician had been notified of Resident #4's poor fluid intake. There was no evidence found that new interventions were attempted to address the resident's poor intake - such as implementing an official intake and output record, notifying the physician, providing the resident small amounts of fluids throughout the day, and assessing when the resident was most likely to drink fluids, and which fluids she was most likely to drink.

Resident #17: The resident was admitted to the facility on 3/17/07. The resident's admitting history and physical revealed that the resident was admitted to the facility to increase the resident's functional status. The resident's diagnoses included dementia, congestive heart failure, hypertension, chronic obstructive pulmonary disease and hypoxemia.

The nursing assistant documentation tool for the month of November 2007 revealed the daily fluid intake (measured in ml):
11/1/07 - 1080
11/2/07 - 480
11/3/07 - 360
11/4/07 - 660
11/5/07 - 360
11/6/07 - 240

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F 327	Continued From page 27 11/7/07 - Resident out of facility part of day 11/8/07 - 740 11/9/07 - 845 11/10/07 - 360 11/11/07 - 720 11/12/07 - 660 11/13/07 - 360 11/14/07 - 360 11/15/07 - 600 11/16/07 - 600 11/17/07 - 420 11/18/07 - 420 11/19/07 - 240 11/20/07 - 240 11/21/07 - 150 11/22/07 - Resident out of facility part of day 11/23/07 - 360 11/24/07 - 360 11/25/07 - 360 11/26/07 - 580 11/27/07 - 600 11/28/07 - 360 11/29/07 - 840 11/30/07 - 360 There was no extra fluid intake recorded on the tool. A nurse stated that this tool was the only record in which fluids were documented. Resident #17's nutrition evaluation, dated 3/21/07, revealed that the resident's daily fluid requirements were 1500 ml. The resident did not achieve that amount of intake for the entire month of November. The evaluation also revealed that the resident was at risk for potential weight loss related to edema and diuretic therapy. The admission nurse's notes revealed that the resident had edema to her feet and ankles. The amount of edema was not recorded on the admission notes. The weight record revealed that	F 327		

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the resident's weight was 120 pounds on 3/20/07 and was down to 100 pounds on 11/5/07. There was no evidence found that the amount of edema was being routinely monitored to see if the weight loss coincided with edema loss.

Resident #17's resident assessment protocol summary had triggered dehydration/fluid maintenance as a problem. On 12/21/07, the dietician was asked if there was a care plan made to address the resident's fluid status since this was triggered as a potential problem. The dietician stated that there was no specific hydration care plan because it was incorporated into the nutritional status care plan. This care plan was reviewed and it revealed that the resident was at risk for dehydration due to Lasix use. The boxes titled monitor mucus membranes and skin turgor were checked. There were no specific interventions such as encourage fluids between meals, evaluate edema, and monitor fluid intake and call dietician if less than a certain amount. The pre-printed nutritional status care plan interventions were dedicated mainly to food consumption.

The nurse's notes, dated 11/15/07 revealed that Resident #17 had weight loss and poor oral intake. The notes, dated 11/22/07, revealed that the resident was found on the floor. It revealed that the resident had orthostatic hypotension. This may be a result of dehydration. There was no evidence found that the cause of the orthostatic hypotension was evaluated.

It was not until 11/27/07 that a nurse notified the physician of Resident #17's poor fluid intake.

Resident #17 was admitted to the hospital on

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F 327	Continued From page 29 11/30/07. The admitting history and physical dated, 11/30/07, revealed the resident was transferred to the hospital for decreased oxygen saturations. The impression was right lower lobe pneumonia, hypoxia, and dehydration. Resident #18: The resident was admitted to the facility on 12/28/06, with several re-admission dates, most recently re-admitted on 12/19/07. The admitting diagnoses included hypertension, chronic obstructive pulmonary disease, lung cancer, diabetes, senile dementia, urinary tract infection, and renal failure. On 12/20/07, Resident #18's medical record was reviewed. The most recent admission assessment of the minimum data set (MDS), dated 10/10/07, assessed Resident #18 as moderately impaired for cognitive skills for daily decision making. The MDS assessment dated 8/23/07 triggered a Resident Assessment Protocol (RAP) for dehydration/fluid maintenance. The written comment by the dietician was, "Resident at risk for dehydration related to recent UTI and antibiotic therapy. Also on HCTZ (hydrochlorothiazide) and has some edema." Review of the care plan did not reveal any specific approaches for encouraging fluids for Resident #18. The assessment dated 10/10/07 triggered a RAP for dehydration/fluid maintenance. The written comment on the dehydration RAP, dated 10/10/07, was, "Triggered due to UTI (urinary tract infection) in past 30 days. Will not proceed with care plan. Resident has adequate fluid intake." The resident was assessed as requiring supervision for eating and drinking. A certified nursing assistant (CNA) working with Resident #18 stated that the resident did not request fluids, but usually	F 327		

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F 327	Continued From page 30 would take them when offered. Review of Resident #18's nursing assistant documentation tool revealed the following daily oral intake: 8/10/07: 1800 ml (cubic centimeters) 8/11/07: 840 ml 8/12/07: 600 ml 8/13/07: 240 ml for breakfast only Review of Resident #18's interdisciplinary progress notes revealed the following entry on 8/14/07, at 12:20 PM, "(Resident #18) appears lethargic with decreased LOC (level of consciousness), displays intermittent confusion, and non-responsiveness, 97.3 (temperature), 120/44 (blood pressure), 64 (pulse), physician notified, transferred to (acute care hospital)." Review of Resident #18's admitting notes from the acute care hospital, dated 8/14/07, revealed the resident had an elevated BUN (blood urea nitrogen) level of 33 (normal range is 8-20) and a creatinine level of 1.5 (normal range is 0.4-1.0). The resident was "hydrated here in the emergency department". The resident's BUN was within normal limits and the creatinine was 1.10 on 8/18/07. Resident #18 was re-admitted to the facility on 8/18/07. Review of Resident #18's interdisciplinary progress notes, dated 8/22/07, revealed the following entry, "Administrative care conference was held this AM with resident's daughter...Daughter wanted, mainly, to be sure that her mother would be hydrated to avoid another recurrence of UTI. ED (Executive Director) informed daughter that fluids could and would be encouraged and that I & O (intake and	F 327		

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F 327	Continued From page 31 output) would be started to monitor resident's intake and output." Review of the resident's record revealed oral intake recorded on the nursing assistant documentation tool. Further review of Resident #18's record failed to reveal documentation for intake and output. On 12/20/07, the Director of Nurses was interviewed. She stated that the only place in the medical record that oral intake was recorded was the nursing assistant documentation tool. Review of Resident #18's nurses notes revealed that on 12/11/07, 9:00 AM, "Resident very warm to touch although her temperature is 99 degrees. She has a moist productive cough, call to physician to order stat chest x-ray, stat CBC (complete blood count) and BMP (basic metabolic panel) to rule out pneumonia or infection." The record indicated the resident declined transport to the hospital at 7:00 PM,and that the family was in agreement, and at 9:00 PM, the family requested transport to the hospital. The physician telephone orders revealed an order written on 12/11/07, "To (an acute care hospital) for evaluation of symptoms per family request". Review of Resident #18's admitting notes to the acute care hospital, dated 12/11/07, revealed that the resident had an elevated BUN level of 26 (normal range is 8-20) and a creatinine level of 1.21 (normal range is 0.4-1.0). The resident "was given a normal saline 250 ml bolus secondary to what appears to her being dehydrated with dry mucous membranes and then at 100 ml per hour after that." Resident #13: The resident was admitted to the facility on 12/13/07 following an acute care stay. Her diagnoses included dementia, anxiety,	F 327		

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esophageal reflux and urinary tract infection. She was receiving intravenous antibiotic therapy.

The Resident Assessment Protocol triggered this resident at being at risk in fluid maintenance due to the presence of a urinary tract infection. However, it was decided not to proceed with care planning because Resident #13 "showed adequate fluid intake by self." The resident has a diagnosis of dementia and the MDS completed on 12/19/07 stated that had there were both short term and long term memory problems and that her cognitive skills for daily decision making was severely impaired.

The initial Nutrition Evaluation completed on 12/17/07 stated that the resident needed a fluid requirement of 1500 ml per day. Review of the Nursing Assistant Documentation Tool revealed the following daily fluid intake measured in ml:
12/14/07 780 ml
12/15/07 720 ml
12/16/07 480 ml
12/17/07 560 ml
12/18/07 600 ml
12/19/07 780 ml
There was no documentation of snack or bedtime fluid intake or of fluids offered during the day.

In an interview with the dietician on 12/20/07, she stated that if a resident consumed all of the liquids offered on their meal trays, they would met the necessary fluid intake needed for adequate fluid maintence.

The Nutritional Status Interdisciplinary Care Plan identified Resident #13 at being at risk for dehydration but the care plan did not specify any approaches to prevent dehydration by the offering

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F 327	Continued From page 33 of, or encouragement to consume fluids. In an interview with the dietician on 12/20/07, she stated that because she is not in the facility on a consistent basis, that the nurses are in a better position to identify and address dehydration in the residents. The nutritional care plan included approaches of the monitoring of mucous membranes and skin turgor. However there was no evidence that the need for this approach had been conveyed to the nursing staff required to make that type of assessment or if those specific monitoring tools were in place. There was no evidence that the resident's beverage choices had been identified or that staff was encouraging the resident to drink. There was no evidence that resident #13 was felt to be a risk for dehydration in spite of her poor fluid intake,her diagnosis of urinary tract infection and her diagnosis of dementia where she may forget to drink.	F 327	**F332 Medication Errors** It is the policy of this facility that medication error rates will be less than five percent. **Residents with Potential Risks** No residents were harmed by failure to comply with this policy. All residents have the potential to be harmed by failure to comply with this policy. **Corrective Action** The Director of Nurses will in-service licensed staff regarding following physicians' orders for correct medication dosage, correct medication and for the requirement that medications administered must have physician's order by February 6, 2008. **Implemented Measure to Ensure Compliance/Compliance Monitoring** The Director of Nurses or her designee will conduct random medication pass observations each month for the next three months and quarterly thereafter. Any findings will be reported to quarterly CQI meeting.	Accepted MB 1/30/08 2/6/08
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review and observation, it was determined that the facility failed to ensure a medication error rate less than five percent. Findings include: The medication pass was observed on three different hallways with four different nurses on 12/18/07 and 12/19/07. The administration of	F 332		

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forty four medications was observed. Four medication errors were noted for a medication error rate of nine percent.

On 12/18/07, at 7:05 AM, medication pass observations were done. The following errors were noted:

1. Medication pass Resident #1: Enteric coated aspirin, 81 mg (milligrams) was administered to the resident. Review of medication pass Resident #1's medical record revealed an order for "Aspirin 81 mg" by mouth once a day. There was no order for enteric coated Aspirin.

2. Medication pass Resident #2: Potassium Chloride (KCl) 10 meq (milli-equivalents) was administered to the resident. Review of medication pass Resident #2's medical record revealed an order for KCl 20 meq to be administered by mouth once a day.

3. Medication pass Resident #3: Enteric coated Aspirin 325 mg and Senna Plus were administered to the resident. Review of medication pass Resident #3's medical record revealed an order for "Aspirin 325 mg" by mouth once a day and "Senakot two tablets" once a day. There was no order for enteric coated Aspirin or the replacement of Senakot two tablets with Senna Plus (which is a combination of Senakot and another drug).

On 12/20/07, the consulting pharmacist was interviewed. He stated that Senna Plus contained Ducosate Sodium 50 mg and Senoside 8.6 mg, and that Senna contained only the Senoside 8.6 mg. Per the Nursing 2006 Handbook, Senokot is euquivalent to Senna. The pharmacist stated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN AT CC HEALTH & REHAB	3050 N ORMSBY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 35 that Senna Plus was not an equivalent to be substituted for Senna.	F 332	**F364 Food** It is the policy of this facility that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor and appearance; and food that is palatable, attractive and at the proper temperature. **Residents with Potential Risks** No residents were harmed by the failure to follow this policy. All residents have the potential to be harmed by failure to follow this policy. **Corrective Action** Dietary Manager will in-service dietary staff on maintaining moisture with starches such as potatoes, rice, etc, maintaining appropriate temperatures for foods, maintaining temperature logs by February 6, 2008. Additional hotel pans will be ordered to provide and hold heat for hot cereals, soups, etc. Bowls will not be stacked any higher than four high to maintain an average temperature of approximately 155 degrees and at no time lower than 140 degrees. Alternating breads, breakfast cakes, pastries will be given to residents with toast provided upon request. Dietary Manager, with Resident Council approval, will attend Resident Council meetings to ascertain overall resident satisfaction with menus, meal temperatures, meal delivery, snack variety and availability.	
F 364 SS=F	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to provide food that was palatable and warm to the facility's residents. Findings Include: On 12/18/07, at 6:55 AM, a tray line was observed in the kitchen. The hot cereals were already in covered bowls. The bowls were in the steamer table. The bowls were stacked up, one on top of the other, up to five bowls high. The bowls that were stacked up were not in direct contact with the steam table. There was no hot cereal observed in a pan directly in the steam table. One bowl of multimeal had a temperature of 118 degrees. The oatmeal had a temperature of 132 degrees Farenheit. These bowls were being put on trays to be delivered to residents. Review of The Essentials of Food Safety and Sanitation Second Edition, Copyright 2000 by Prentiss-Hall revealed that all foods to be prepared and served hot must be cooked to and held at no less than 140 degrees F. All foods to be served cold must be chilled and held at no	F 364		

Accepted MP 1/30/08

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F 364	Continued From page 36 more than 41 degrees F. On 12/19/07, a breakfast test tray was ordered. An oatmeal bowl that was stacked on top of other bowls in the steam table was placed on the tray. An observation was made that food was placed on a hot plate and covered. Delivery of the trays on one unit were made in an open aired cart. The test tray was on one of these carts. The test tray was the last tray taken off the cart at 7:30 AM. The oatmeal was sampled and was cold and unpalatable. The toast was sampled and was soft and cold. The toast did not have the texture of toast when sampled. While sampling the tray a resident in the dining area stated that the food was normally cold. The following food temperatures were noted of the food on the sample tray: Oatmeal: 120 degrees F Egg: 110 degrees F Milk: 53 degrees F Juice: 56 degrees F Water: 54 degrees F Surveyors conducted a group interview on 12/18/07, at 10:00 AM. It was reported that when the group was asked about food that is supposed to be hot being served too cold, three residents verbalized that the food was cold and the rest of the residents in the group nodded their heads yes in agreement. On 12/18/07, a lunch test tray was sampled. The scalloped potatoes had a gummy, undercooked texture. The dietary manager stated he had sampled the potatoes and agreed with the assessment. A surveyor made a general observation of one of the dining areas on	F 364	**Implemented Measure to Ensure Compliance/Compliance Monitoring** Dietary Manager will monitor food temperatures by measuring temperatures on a test tray at least three time per week. Test tray will be last tray delivered. Results will be reported to the quarterly CQI meeting. Executive Director will monitor palatability by consuming at least three meals per week and filling out an "E.D. Meal Satisfaction Log" for each meal consumed. Meal Satisfaction Log will be reported to Dietary Manager.	2/6/08

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F 364	Continued From page 37 12/18/07 at 12:40 PM. Nine residents' plates were observed and it was noted that no one had eaten the potatoes.	F 364	**F368 Frequency of Meals** It is the policy of this facility that snacks are offered at bedtime daily.	
F 368 SS=F	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, it was determined that the facility failed to offer the residents a daily bedtime snack, and 1 of 25 residents verbally expressed being hungry at bedtime. (Resident #5). Findings included: Resident #5: The resident was admitted to the facility on 12/10/2006 with diagnoses of multiple sclerosis, urinary retention, irritable bowel syndrome, osteoporosis and depressive disorder.	F 368	**Residents with Potential Risks** All residents have the potential to be harmed by failure to follow this policy. **Corrective Action** Resident #5 will be offered snacks at bedtime daily. Two snack carts will be stocked by kitchen staff each evening. Each cart will offer a variety of snacks that change on a frequent basis to increase and maintain interest in the snacks. CNAs will be in-serviced in taking carts down each hallway at HS, going into each room (leaving cart in hallway) and offering snack to each resident. Census sheets will be on each cart to aid in documenting snacks accepted, consumed and refused. Staff Developer will in-service Licensed staff and CNAs on snack Program by February 6, 2008. Activity Director will inform residents on type and availability of snacks through Resident Council. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** Licensed nurses will ensure compliance and report any findings to Director of Nurses or her designee.	2/6/08

Accepted MJ 1/30/08

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F 368	Continued From page 38 On 12/18/07, at 2:45 PM, Resident #5 stated that she does not get her bedtime snack and would like to have her snack because she becomes hungry without snacks. The nursing assistant documentation tool had HS (bedtime) snack hand written in under the diet portion. No snacks were documented as offered from December 12/1/07 through 12/17/07. On 12/20/07, at 1:30 PM, in a telephone interview, the facility dietician stated that bedtime snacks should always be offered to residents. See Tag F325. During the group resident meeting at 10:00 AM on 12/18/07, when asked about the food in the facility, five of the residents stated and agreed that an evening snack was not offered. In an interview with the Food services Manager at 2:10 PM on 12/18/07, he stated that physicians ordered snacks and a variety of general snacks including crackers and fruit are placed in the two nourishment rooms located next to the resident units each evening at 7:00 PM. He further stated that there are kitchen staff present until 8:30 PM each evening. He then stated that he had no knowledge if snacks were actually consumed. When interviewed on 12/18/07 at 2:20 PM, the Director of Nurses (DON) stated that each evening the snacks are taken from the nourishment rooms to the nurses station on each unit. The snacks are available if a resident wishes, but she acknowledged that snacks are not verbally offered to each resident, but had to be requested. She further stated that currently there is no mechanism in place to record consumption of a snack.	F 368		

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F 368	Continued From page 39 In an interview with the staff development coordinator at the same meeting, she stated that there is no written policy as to what constitutes bedtime care including the offering of a bedtime snack. Review of the Admissions packet for new residents revealed that it was stated that snacks were part of the services included in the monthly rate. In interivew, an unidentified employee stated that she was concerned about a resident with significant weight loss. When the resident expressed an interest in a milk shake, the employee asked the Food Services Manager to make one for specific for that resident. The employee stated that she was told that it couldn't be done because then everyone would want one.	F 368	**F431 Pharmacy Services** It is the policy of this facility that drugs and biologicals be labeled with the expiration date and stored under proper temperature controls. **Residents with Potential Risks** All residents have the potential to be harmed by the failure to follow this policy. **Corrective Measures** Director of Nurses will in-service licensed staff to maintain cleanliness of medication refrigerators, requirement that refrigerator temperatures must be done daily, location of the temperature log, that opened medications are to be dated upon opening and that expired medication must be discarded.	
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	Noc shift will record refrigerator temperatures daily. In-service will be completed by February 6, 2008. Cleaning schedule for refrigerators will be developed and posted on refrigerators for documentation that refrigerator was cleaned. Medications will be dated upon opening and discarded according to the manufacturer's storage instructions. **Implemented Measure to Ensure Compliance/Monitoring of Compliance** The Director of Nurses or her designee will do weekly rounds for one month and then monthly thereafter to ensure deficiencies are corrected.	2/6/08

Accepted
MD
1/30/08

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F 431	Continued From page 40 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to label drugs and biologicals with the expiration date when appropriate and to assure that all drugs and biologicals were being stored under the proper temperatures. Findings include: On 12/18/07 at 11:30 AM, inspection of the medication room for the Classic Halls, found that a vial of purified protein derivative for PPD testing was observed to have been opened and dated 10/16/07. Review of the manufacturer's storage instructions on the package insert found that the bottle should be discarded after it has been open for 30 days or after the expiration date. The medication refrigerator was dirty and did not have documentation of the temperature having	F 431		

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F 431	Continued From page 41 been checked for 12/13-12/14/07 to assure that the medications were being stored at the proper temperatures. The specimen refrigerator did not documentation of temperatures being checked from 12/12-12/14/07. On 12/18/07 at 11:40 AM during observation of the medication room for the Brookside unit, it was noted that a vial of Procrit for an individual resident was opened but not dated as to the date opened. In addition a vial of PPD testing material was opened but not dated. The medication refrigerator was in need of defrosting. The log for recording the refrigerator temperatures could not be located in the medication room. Two licensed nurses working Brookside were asked for the location of the temperature log. Both nurses indicated that they did not know where the log could be located. The DON was notified that the logs could not be located and she instituted a search. She later reported that she could not locate the temperature logs for the Brookside medication refrigerator.	F 431	**F442 Preventing Spread of Infection** It is the policy of this facility that when the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident. **Residents with Potential Risks** All residents have the potential to be harmed by the failure to comply with this policy. **Corrective Action** Resident #10 has readmitted from acute care without requiring isolation precautions. Red signs stating : "Visitors: Please report to the Nursing Station Before Entering" have been created and laminated and provided to each nursing station for display outside the room of any resident requiring isolation. Director of Nurses or her designee will in-service Licensed staff regarding the requirement that these signs be posted outside the room of any resident requiring isolation by February 6, 2008.	Accepted MF 1/30/08
F 442 SS=D	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility policy, it was determined that the facility failed to define the precautions needed for	F 442		

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F 442	Continued From page 42 "isolation" to visitors in order to prevent the spread of an identified infection for 1 of 23 residents. (Resident #10) Findings include: Resident #10: The resident was admitted to the facility on 10/08/07. The diagnoses included cerebral vascular accident, hypertension, coronary artery disease, aphasia and a brain neoplasm. He was in isolation for Clostridium difficile (c-diff) infection. Review of the record revealed that Resident #10 had an order written, on 10/08/08, for C-diff precautions, gloves and gowns. During the initial tour of the facility, on 12/17/07, it was noted that there was a red isolation cart outside of the resident's room. On the door frame was a red sign stating "isolation." On the afternoon of 12/17/07, LPN #3 was interviewed regarding the isolation of the resident. When asked how any visitor to the resident would know what they were to do regarding this resident's isolation, she replied, "I would hope that they would check at the nurses station. We can't just put up more and more signs," Review of the facility policy on "Isolation Notices", Under Policy Interpretation and Implementation, it stated that when isolation precautions are implemented, a red sign that has the words, "Visitors: Please report to the Nurses Station Before Entering" printed on it must be placed at the entrance/ doorway of the resident's room.	F 442	**Implemented Measure to Ensure Compliance/Monitoring of Compliance** Licensed nurse to display red sign required for isolation precaution on resident's door. Director of Nurses will monitor for compliance through regular rounds to ensure deficiency is corrected. 1/30/08 per PC J. Stefanski DON has binder with dailys of months where she tracks monitoring of Compliance. this will be added to that binder. MB Garraza RN HFS III	2/6/08